No. 12-98

IN THE

Supreme Court of the United States

ALBERT A. DELIA, SECRETARY, NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

E. M. A., A MINOR, BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON, WILLIAM EARL ARMSTRONG, AND SANDRA ARMSTRONG,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF FOR THE NATIONAL GOVERNORS ASSOCIATION, NATIONAL CONFERENCE OF STATE LEGISLATURES, COUNCIL OF STATE GOVERMENTS, NATIONAL ASSOCIATION OF COUNTIES, INTERNATIONAL CITY/COUNTY MANAGEMENT ASSOCIATION, NATIONAL LEAGUE OF CITIES, UNTED STATES CONFERENCE OF MAYORS, GOVERNMENT FINANCE OFFICERS ASSOCIATION, AND CITY OF NEW YORK AS *AMICI CURIAE* SUPPORTING PETITIONER

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INTEREST OF *AMICI CURIAE* [1]

The National Governors Association (NGA), founded in 1908, is the collective voice of the Nation's governors. NGA's members are the governors of the 50 States, three Territories, and two Commonwealths.

The National Conference of State Legislatures (NCSL) is a bipartisan organization that serves the legislators and staffs of the nation's 50 States, its Commonwealths, and Territories. NCSL provides research, technical assistance, and opportunities for policymakers to exchange ideas on the most pressing state issues. NCSL advocates for the interests of state governments before Congress and federal agencies, and regularly submits *amicus* briefs to this Court in cases, like this one, that raise issues of vital state concern.

The Council of State Governments (CSG) is the Nation's only organization serving all three branches of state government. CSG is a region-based forum that fosters the exchange of insights and ideas to help state officials shape public policy. This offers unparalleled regional, national, and international opportunities to network, develop leaders, collaborate, and create problem-solving partnerships.

The National Association of Counties (NACo) is the only national organization that represents county governments in the United States. NACo provides

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[1] The parties have consented to the filing of this brief, and their letters of consent are on file with the Clerk (Rule 37.2). This brief was not written in whole or in part by the parties' counsel, and no one other than the *amicus* made a monetary contribution to its preparation (Rule 37.6).

essential services to the Nation's 3,068 counties through advocacy, education, and research.

The International City/County Management Association (ICMA) is a nonprofit professional and educational organization of over 9,000 appointed chief executives and assistants serving cities, counties, towns, and regional entities. ICMA's mission is to create excellence in local governance by advocating and developing the professional management of local governments throughout the world.

The National League of Cities (NLC), founded in 1924, is the oldest and largest organization representing municipal governments throughout the United States. Working in partnership with 49 state municipal leagues, NLC serves as a national advocate for the more than 19,000 cities, villages, and towns it represents. Its mission is to strengthen and promote cities as centers of opportunity, leadership, and governance.

The U. S. Conference of Mayors (USCM), founded in 1932, is the official nonpartisan organization of all United States cities with a population of more than 30,000 people, which includes over 1,200 cities at present. Each city is represented in the USCM by its chief elected official, the mayor.

Government Finance Officers Association (GFOA) is the professional association of state, provincial, and local finance officers in the United States and Canada. The GFOA has served the public finance profession since 1906 and continues to provide leadership to government finance professionals through research, education, and the identification and promotion of best practices. Its 17,500 members are

dedicated to the sound management of government financial resources.

The City of New York (NYC) is a municipal corporation in New York State. Under New York State law, NYC administers the Medicaid program and is financially responsible for 25 percent of nearly all Medicaid costs for its residents. NYC ranks third in Medicaid spending in the United States after New York State and the State of California.

These groups submit this brief as *amici curiae* because their members will be directly affected by the Court's decision in this case. Through Medicaid, *amici*'s members fund necessary health care for their poorest inhabitants at this time of historic pressure on State and local resources. *Amici* support the petitioner in this case because, as this brief explains, North Carolina's Medicaid recovery statute, as construed by the North Carolina Supreme Court, provides an efficient, fair, and reasonable method for States to recover costs imposed on State budgets by tortfeasors.

STATEMENT OF THE CASE

Amici rely on the statement of the case set forth in the petitioner's brief.

SUMMARY OF ARGUMENT

Through their Medicaid programs, the States pay out enormous portions of their budgets to provide medical care to their neediest residents, and those costs are spiraling upward at an increasing rate. Reimbursement from third-party tortfeasors who have wrongly forced the State to incur even higher Medicaid expenses is one of the few ways that States

can defray their costs. Medicaid leaves considerable discretion to the States in implementing its requirements, including as to how to economically seek such third-party reimbursement.

When a Medicaid recipient settles a claim against a tortfeasor, the State is entitled, and often is required, to recoup its expenses. As construed by the North Carolina Supreme Court, North Carolina law limits the State's recovery to the amount that the recipient and the tortfeasor agree in good faith should be allocated to medical expenses. But in the situation presented here, where the parties failed to exercise their option to expressly allocate their settlement, North Carolina law provides a default recovery of one-third of the settlement or the full amount of the State's expenditure, whichever is less. That is a reasonable way, in that limited and avoidable situation, for the State to avoid the costs of interposing itself in settlement talks or participating in a mini-trial, after the fact, on the question of what might be a proper allocation. And it makes perfect sense as a matter of law, for under common law contract principles applied in North Carolina, and in the absence of some other express allocation, the parties' settlement agreement simply incorporates the default one-third allocation provided by the North Carolina statute.

North Carolina's statute is further reasonable because it takes a relatively generous approach to third-party reimbursement. It leaves the Medicaid recipient with two-thirds of any recovery even when the State has spent far more than that paying for that recipient's medical care. And this generous approach has been specifically approved as consistent with federal law by the federal agency that admin-

isters Medicaid, an interpretation of the federal Medicaid statute to which this Court should defer. For these reasons, the North Carolina statute should be upheld, and the Fourth Circuit's decision should be reversed.

ARGUMENT

I. STATES HAVE, AND REQUIRE, SUBSTANTIAL DISCRETION IN IMPLEMENTING MEDICAID

A. States face constant, increasing budgetary pressure, and require latitude in seeking Medicaid reimbursement

As with all healthcare costs in the United States, the costs to States of providing medical care to their poorest citizens through Medicaid have been increasing for decades. These costs have grown significantly faster than the national economy, and faster than tax revenue. CENTERS FOR MEDICARE & MEDICAID SERVICES, OFFICE OF THE ACTUARY, 2011 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR MEDICAID ii (Mar. 16, 2012) [hereinafter 2011 ACTUARIAL REPORT]. From 1970 to 2010, combined federal and state Medicaid expenditures have quintupled from 0.5 percent of the United States' gross domestic product to 2.7 percent. *Id.* The recent economic downturn—the nation's deepest recession since the Great Depression—has driven Medicaid costs higher even more sharply.

As economic conditions have deteriorated and Americans have lost jobs and health insurance, the States' Medicaid programs have stepped in to fill coverage gaps. Medicaid enrollment and resulting federal and state expenditures have skyrocketed. In

2009 alone, Medicaid expenditures nationwide increased by 7.6 percent and enrollment grew by an estimated 6.5 percent. *Id.* at 17. Between 2000 and 2009 (the most recent date for which data is available), the number of Medicaid beneficiaries in North Carolina grew from 1.2 million to 1.8 million people. U. S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2012, TABLE 152, MEDICAID – SUMMARY BY STATE: 2000 TO 2009 (2012). As a result, North Carolina's Medicaid disbursements nearly doubled from $4.8 billion to $9.6 billion. *Id.* These surges in Medicaid enrollment and expenditures show no signs of abating. The U.S. Department of Health and Human Services estimates expenditures will increase at an average annual rate of 8.1 percent and reach $871 billion by 2020. 2011 ACTUARIAL REPORT, at iv.

Simultaneously, the States' revenue sources to cover Medicaid and other expenditures have been shrinking. The majority of State expenses are paid for with funds from personal income taxes, sales taxes, and corporate income taxes. MARTHA HEBERLEIN & JOAN ALKER, STATE BUDGET WOES: REVENUE DECLINES, NOT MEDICAID SPENDING, ARE TO BLAME 1 (Mar. 2012). These taxes are directly affected by the overall health of the economy, and have steadily decreased in the past several years as the employment rolls have contracted and as personal income has declined. *Id.* at 2. By the second quarter of 2009, "income tax collections were 27% below their level one year earlier and total state taxes were 17% lower" while "spending demand continued or escalated, particularly for Medicaid." KAISER COMMISSION ON MEDICAID AND THE UNINSURED, UPDATE: STATE BUDGETS IN RECESSION AND RECOVERY 1 (2011). In

North Carolina, the State's $9.6 billion in Medicaid expenditures in 2009 were nearly 50 percent of general fund revenues for that year. *See* NORTH CAROLINA DEP'T OF REVENUE, STATISTICAL ABSTRACT OF NORTH CAROLINA TAXES 2011, PART II, SUMMARY OF STATE GENERAL FUND REVENUE COLLECTIONS, TABLE 2, STATE GENERAL FUND: TAX REVENUES BY SOURCE (2012). Even if the economy improves and tax revenues increase, in 2014 many States will begin participating in the Patient Protection and Affordable Care Act's Medicaid expansion, which will significantly increase Medicaid participation and expenditures. The expansion will be totally funded by the federal government only through 2016. *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2,566, 2,601 (2012).

B. The Medicaid statute gives States the latitude they need to accomplish Medicaid's ends

In light of these fiscal pressures, it is vital that States have every option open to them to defray the costs of Medicaid. And the Medicaid statute in fact grants States substantial discretion in implementing Medicaid generally and in pursuing recovery from third-party tortfeasors in particular.

While the federal government contributes substantially to Medicaid, the States bear up to 50 percent of the costs, including the recent increases. *See, e.g.*, Federal Financial Participation in State Assistance Expenditures, 75 Fed. Reg. 69,082, 69,083 (Nov. 10, 2010) (setting federal medical assistance percentages). The States take the federal government's Medicaid funds subject to the conditions that Congress has imposed, but the "Medicaid statute is de-

signed to advance cooperative federalism." *Wisconsin Department of Health & Family Services v. Blumer*, 534 U. S. 473, 495 (2002). Consistent with their responsibility to pay out a large share of the costs of Medicaid, and with the duty that they have assumed to serve, *parens patriae*, as the health insurer of last resort for those in need, the States have broad discretion in designing and implementing their Medicaid programs.

States are responsible, for example, for deciding the most basic terms of Medicaid services: who will be eligible for Medicaid; what services they may receive; the rates for services; and the standards to which providers are held. *See* 42 U. S. C. §§ 1396a(a)(5), (9). As this Court has observed, the federal Medicaid statute "confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be 'reasonable' and 'consistent with the objectives' of the Act." *Beal v. Doe*, 432 U. S. 438, 444 (1977); *see also*, *e.g.*, *Alexander v. Choate*, 469 U. S. 287, 303 (1985) ("The Act gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in 'the best interests of the recipients.'").

More generally, when applying a "cooperative" federal-state regime like Medicaid, this Court has "not been reluctant to leave a range of permissible choices to the States, at least where the superintending federal agency has concluded that such latitude is consistent with the statute's aims." *Blumer*, 534 U. S. at 495. One of the mandatory conditions of receiving Medicaid funding is that, as the Fourth Circuit observed, "states participating in the Medi-

caid program" must "seek reimbursement from third-party tortfeasors for health care expenditures made on behalf of Medicaid beneficiaries who are tort victims." Pet. App. 2a; *see* 42 U. S. C. § 1396a(a)(25). States are required to make "all reasonable efforts" to ascertain the liability of third parties for expenses paid by Medicaid, and are further required to enact laws providing that "to the extent" that Medicaid has paid medical assistance to an individual, "the State is considered to have acquired the rights of such individual to payment by any other party" to reimburse the State for that assistance. 42 U. S. C. §§ 1396a(a)(25)(A), (H). But here again, and importantly in this case, the methods for ascertaining liability and obtaining reimbursement are generally left to the States.

II. NORTH CAROLINA'S REIMBURSEMENT REGIME IS A REASONABLE EXERCISE OF DISCRETION

A. North Carolina reasonably allocates settlements when the parties have declined to allocate—and encourages allocation

To implement the requirement that States seek reimbursement from tortfeasors, North Carolina law provides that a Medicaid recipient's right to recover medical expenses from a third-party tortfeasor belongs to the State. N. C. GEN. STAT. § 108A-59 (2012). It also provides that, where a Medicaid recipient brings an action against a third-party tortfeasor and the action concludes through a judgment or settlement, the recipient's attorney is bound to, "out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from

a third party by reason of injury or death, distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary," but that "the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered." N. C. GEN. STAT. § 108A-57 (2012). The State's recovery is thus the lesser of one-third of the total amount of recovery, or all of the State's medical expenses. *Id.*

In *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U. S. 268 (2006), this Court held that "[t]here is no question that the State can require an assignment of the right, or chose in action, to receive payments for medical care" but "that does not mean that the State can force an assignment of, or place a lien on, any other portion of [a Medicaid recipient's] property." *Id.* at 284. In *Ahlborn*, unlike here, the parties had all expressly agreed on a portion of the settlement that related to medical care. This Court held that the State could not recover more than that agreed upon amount.

The Supreme Court of North Carolina subsequently held that "*Ahlborn* * * * controls when there has been a prior determination or stipulation as to the medical expense portion of a plaintiff's settlement. In those cases, the State may not receive reimbursement in excess of the portion so designated." *Andrews ex rel. Andrews v. Haygood*, 669 S.E.2d 301, 313 (N.C. 2008).[2] *Ahlborn* and *Andrews*

[2] *Amici* assume that a manipulated stipulation, in which a tortfeasor and a Medicaid recipient agree in bad faith to allocate an unreasonably small portion of a settlement to medical expenses in order to thwart a State's right of recovery, would not be entitled to this kind of controlling weight even under

thus give a Medicaid recipient a clear method for delineating the State's entitlement: specify the allocation in the settlement agreement.

In this case, the settlement agreement, which is between the individual for whom the State paid medical expenses and the party who is accused of causing the harm, does not specify that any portion of the settlement amount was intended to cover non-medical expenses, and does not specify a portion that was intended solely as reimbursement for medical expenses. *See* Pet. App. 3a ("The settlement agreement did not allocate separate amounts for past medical expenses and other damages."). Consequently, the only question that the Court has to answer in this case is whether a State may recover under a statutory allocation scheme like North Carolina's in those narrow circumstances where the parties settle a tort dispute, but fail to specify any allocation for medical expenses.

As in any circumstance in which a State has discretion to choose the means to accomplish a statutory end, there are several options. Two potential options for dealing with the non-allocation scenario, suggested by the Fourth Circuit, are: (1) State participation in the settlement; and (2) a post-settlement hearing to determine the State's share. Both are impractical and impair the ends of Medicaid, have been rejected by North Carolina, and should be rejected by this Court.

First, the State could participate in settlement discussions involving Medicaid recipients. The purpose would be for the State to agree in advance to the

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Ahlborn. That issue is not before the Court in this case and ought not be addressed on these facts.

apportionment of any settlement, or withhold consent to any settlement that failed to protect the State's right to recover. Requiring this approach would be a significant burden on the State. The costs of sending a representative to every settlement conference in which a State recovery might be at issue would be prohibitive. Indeed, the Medicaid statute requires the State to seek recovery only when the benefits of seeking recovery are likely to outweigh the costs of pursuing it. 42 U. S. C. § 1396a(a)(25)(H). Settlement negotiations are inherently speculative; there is no guarantee that a settlement will be reached or that any recovery will be forthcoming. So there is a guaranteed waste of resources built into such a regime. That is not acceptable because spending State funds on participation in speculative settlement talks necessarily diverts funds from the ultimate goal of Medicaid: to provide medical care to the needy.

Second, the Fourth Circuit suggested that a hearing should be held, after any settlement, to determine the share that belongs to the State. This option, like the first, is wasteful. Hearings are expensive and time consuming. They would similarly divert scarce resources that could otherwise be spent providing the States' share of Medicaid coverage.

Worse, the Fourth Circuit's rule requiring a hearing where the State does not participate in the settlement may encourage parties not to allocate, and may bar State recovery as a practical matter in many cases. Parties will reasonably anticipate that the burden of holding a hearing, with an uncertain outcome, will often lead States to conclude that pursuing recovery is not cost effective. States will not pursue recovery under those circumstances. And if a State has no procedural mechanism in place for

holding such a hearing, States may simply be incapable of seeking recovery until a hearing mechanism is created by legislation.

Moreover, the proper objective of the hearing is unclear. The Fourth Circuit held that "the sum certain allocable to medical expenses must be determined, in the absence of a stipulation by the affected parties, by judicial determination or some similar adversarial process, before the state may recoup its Medicaid outlays." Pet. App. 13a. The proposal that a hearing be held supposes that the parties will have agreed to an allocation even if they have failed to memorialize it in their settlement agreement.

There is no reason to suppose that the parties will usually have agreed upon, despite failing to express, such an allocation. To the contrary, it is presumptively true that any settlement agreement will fully express what the parties actually agreed to. North Carolina law, for example, incorporates the familiar principle that "where the parties have deliberately put their engagements in writing in such terms as import a legal obligation free of uncertainty, it is presumed the writing was intended by the parties to represent all their engagements as to the elements dealt with in the writing." *Neal v. Marrone*, 79 S.E.2d 239, 242 (N.C. 1953). So in a case like this one, the fact that the parties did not set forth an allocation in their settlement means there was no allocation agreed upon. The hearing contemplated by the Fourth Circuit here would be a fishing expedition, unlikely to uncover some secret allocation existing in fact, and indeed the common law of contracts would generally deem there to have been no agreement on any such unexpressed allocation as a matter of law.

Having rejected these options, North Carolina has instead adopted the default-allocation rule that is challenged here. That rule, as noted, provides that the State may recover no more than one-third of any settlement that fails to expressly allocate a portion of the settlement to medical expenses. North Carolina's solution has significant advantages to these other options. It is efficient because it allows for the simple determination of a sum certain. It does not involve the State in speculative pre-settlement proceedings, saving scarce Medicaid resources while leaving the parties to manage their dispute without interference and thus easing the path to settlement. It also does not require a *post hoc* judicial inquiry into an allocation that likely does not exist as a matter of fact.

Perhaps most importantly, North Carolina's rule is merely a default, entirely avoidable by parties wishing to avoid it. As construed by *Andrews* in light of *Ahlborn*, North Carolina law gives the settling parties the option, in every case, to agree on an allocation for medical expenses. That allocation will bind the State and set its recovery so long as it is made in good faith. There is every reason to encourage parties to take that option.

But where the parties fail to take that option, there is no necessary tension between the North Carolina default regime and *Ahlborn*. A settlement with no express allocation simply incorporates North Carolina's default allocation as a matter of law. As this Court long ago recognized, "existing laws [are] read into contracts in order to fix obligations as between the parties." *Home Building & Loan Association v. Blaisdell*, 290 U. S. 398, 435 (1934); *see also Farmers' & Merchants' Bank of Monroe, N. C. v. Federal Reserve Bank of Richmond, Va.*, 262 U. S. 649, 660

(1923) ("Laws which subsist at the time and place of the making of a contract, and where it is to be performed, enter into and form a part of it, as fully as if they had been expressly referred to or incorporated in its terms.").

This principle is specifically true as a matter of North Carolina law: "Valid laws existing at the time and place a contract is entered into and at the place where it is to be performed, are read into and become a part of a contract unless a clear intent to the contrary is disclosed by the contract" because "contracting parties are presumed to contract in reference to the existing law; indeed, they are presumed to have in mind all the existing laws relating to the contract." *Poole & Kent Corp. v. C. E. Thurston & Sons, Inc.*, 209 S.E.2d 450, 455 (N.C. 1974). Thus, in a case like this, where the parties make no express, alternative allocation, the parties are deemed by operation of North Carolina law to have accepted the default allocation set forth in the statute. That completely resolves any tension that might otherwise be perceived with *Ahlborn*, because it means that a settlement like the one at issue here, as a matter of law, allocates one-third of the recovery to cover the State's medical expenses.

B. North Carolina is more generous to Medicaid recipients than private insurers

North Carolina's law is also a reasonable exercise of the State's discretion because it leaves Medicaid recipients in a considerably better position than many private insurers would allow. In the private insurance context, one of the standard rules that apply where the insured is not fully reimbursed for a

loss caused by a tortfeasor is the "insurer-first" rule, in which the insurer is first made whole out of any recovery from a third party, and the insured takes the balance. *See* ROBERT E. KEETON & ALAN A. WIDISS, INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES AND COMMERCIAL PRACTICES § 3.10(b)(1) (1988).

This Court recently allowed a health insurer sponsor to pursue "insurer-first" recovery from a tort victim in the ERISA context. *See Sereboff v. Mid-Atlantic Medical Services, Inc.*, 547 U. S. 356 (2006). And while some States disapprove "insurer-first" recovery, several States allow it and it is common for private insurers to require it in those States. *See*, *e.g.*, *North Buckeye Education Council Group Health Benefits Plan v. Lawson*, 814 N.E.2d 1210 (Ohio 2004); *Trogub v. Robinson*, 853 N.E.2d 59 (Ill. App. Ct. 2006); *see also Met Life Auto & Home Insurance Co. v. Lester*, 719 N.W.2d 385 (S.D. 2006) (allowing "insurer-first" recovery under a property insurance contract).

North Carolina's statute is substantially more generous to Medicaid recipients than the "insurer-first" regime. First, it allows a Medicaid recipient to make a good faith allocation to avoid the one-third maximum apportionment otherwise imposed by the statute. Second, it guarantees a Medicaid recipient will receive at least two-thirds out of any tort settlement, regardless of what the State has paid for medical expenses. North Carolina's statutory scheme thus reflects a reasonable, and indeed generous, approach to recovery by the State-as-insurer, one that many private insurers would eschew.

C. This Court should approve North Carolina's statute in light of the administering agency's approval

In short, North Carolina's statute provides a reasonable, efficient solution to a difficult problem. It allows the State to recoup costs, while not only giving the parties complete power to negotiate around the default rules, but also promising a substantial recovery for Medicaid recipients in every case in which they do not stipulate to an allocation. Additionally, the North Carolina statute and the decision in *Andrews*, holding that North Carolina's statute is consistent with *Ahlborn*, have already been analyzed and approved by the Centers for Medicare & Medicaid Services (CMS), "[t]he federal agency in charge of administering Medicaid." *Douglas v. Independent Living Center of Southern California Inc.*, 132 S. Ct. 1204, 1207 (2012). This Court should approve North Carolina's statute in light of that agency approval.

After *Ahlborn*, CMS opined on what actions a State could take to ensure recovery from tortfeasors while remaining consistent with the Court's decision. In its memorandum, the agency noted that "State tort or insurance liability provisions are a matter of State law and could be utilized to mitigate the adverse affects of the decision," and advised that, consistent with *Ahlborn*, "a State can enact laws which provide for a specific allocation amongst damage[s], *i.e.*, pain and suffering, lost wages, and medical claims." Pet. App. 129a. The North Carolina statute here, as construed by *Andrews*, does exactly that in the limited context where the parties have declined to agree on an allocation. CMS's generally stated views support approval of the North Carolina regime.

CMS then specifically considered and approved North Carolina's statute. CMS noted that this Court in *Ahlborn* "did not mandate a specific method for determining the medical expense portion of a plaintiff's settlement," and expressed its view that "States have leeway to develop a reasonable statutory scheme for apportioning medical expenses." Pet. App. 141a. The agency stated that CMS "agree[s] with the decision" of the North Carolina Supreme Court in *Andrews*, and expressed the view that both the *Andrews* decision and the State's attempt to recover in *Andrews* were not in "conflict with CMS['s] guidance." Pet. App. 142a.

Where CMS has considered and approved a state statute implementing Medicaid, this Court should defer to the agency's view. First, as noted, this Court has "not been reluctant to leave a range of permissible choices to the States, at least where the superintending federal agency has concluded that such latitude is consistent with the statute's aims." *Blumer*, 534 U. S. at 495. Here the administering agency has indeed specifically concluded that "States have leeway to develop a reasonable statutory scheme for apportioning medical expenses." Pet. App. 141a. This Court should leave open the States' options for recovering, consistent with the agency's view that the States should have that "leeway."

Second, this Court should defer to the agency's reliance upon the decision in *Andrews*. This Court recently reiterated the importance of deferring to CMS's opinion on state statutes implementing Medicaid where "the agency is comparatively expert in the statute's subject matter" and "the agency's expertise is relevant in determining [the statute's] application." *Douglas*, 132 S. Ct. at 1210 ("review of agency action

requires courts to apply certain standards of deference to agency decisionmaking") (citing *National Cable & Telecommunications Association v. Brand X Internet Services*, 545 U. S. 967 (2005) and *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U. S. 837 (1984)). *Id*. In *Douglas*, the Court remanded following CMS's announcement of its support for a number of state statutes, finding that CMS's new approval of the statutes might change the plaintiffs' ability to challenge them. *Id.* Here, where CMS has considered the validity of North Carolina's statute in balancing federal requirements, state needs, and citizens' rights, the Court should respect that determination and similarly uphold the statute.

CONCLUSION

The decision of the Fourth Circuit should be reversed.

Respectfully submitted,

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